Testimony on

Long-Term Care

by

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I. INTRODUCTION

Good afternoon, Mr. Chairman and members of the subcommittee. I am Karen Ignagni, President and CEO of America's Health Insurance Plans (AHIP), which is the national association representing nearly 1,300 private sector companies providing health insurance coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and also have a strong track record of participation in public programs.

AHIP's members, who represent about 90 percent of the current long-term care insurance marketplace, share your commitment to meeting the long-term care needs of our nation's aging population and we appreciate the opportunity to testify on this important issue. We applaud Congress for enacting legislation earlier this year to expand long-term care partnerships. We particularly want to thank members of this committee for your leadership on this critically important legislation.

My testimony today will focus on five areas:

(1) Broadening the conversation on long-term care to recognize the continuum of health care services Americans will need throughout their lives;

(2) The importance of moving forward to implement the newly expanded long-term care partnerships in a timely manner;

(3) The innovative strategies AHIP members are using to contain costs and improve quality in Medicaid;

(4) An overview of private long-term care insurance, including the financial protection it offers consumers and the cost savings it provides to Medicaid and Medicare; and

(5) Recommendations for additional policy changes that should be pursued to help more Americans secure protection against long-term care costs.

II. BROADENING THE CONVERSATION

Our members urge the subcommittee to take an approach to long-term care that broadens the health care discussion to focus on the continuum of health care services that people need throughout their lives. Our current health care system focuses primarily on treating episodes of acute illness, rather than managing chronic conditions. This is true despite the fact that 20 percent of all Medicare beneficiaries – chronically ill patients with five or more medical conditions – accounted for more than two-thirds of the Medicare program's costs in 2004. Likewise, long-term chronic care management is a key cost and quality issue for Medicaid. Our tax system also takes a narrow view of our nation's health care needs by orienting incentives toward the coverage of acute care benefits.

The aging of the baby-boom generation – the 77 million Americans born between 1946 and 1964 – poses multiple challenges for policymakers. More men and women are approaching retirement than ever before and they will live longer into old age than any previous generation. The U.S. Census Bureau estimates that between 2003 and 2030, the population age 65 and older will increase from 36 million to 72 million, reaching twenty percent of the total population. Meanwhile, the population of those aged 85 or older – the population most likely to need long-term care – is projected to increase from 4.7 million in 2003 to 9.6 million in 2030, and then double again to 20.9 million by 2050.

In the next 30 years, more than half the U.S. population will be living with at least one chronic condition. When narrowing this profile to seniors, Census Bureau data suggest that approximately 80 percent of seniors have at least one chronic condition, and 50 percent of those have two or more chronic conditions. Chronic illnesses such as cancer, diabetes, Alzheimer's disease and hypertension exacerbate age-related health problems and increase the likelihood of needing long-term care. Currently, nearly half of all nursing home residents have Alzheimer's disease. By 2050, the Alzheimer's Association estimates that 14 million baby boomers, nearly one in five, will find themselves living with the disease. We need to make major adjustments to address 21st-century realities and our aging population. At the same time, we need to explore a range of public-private partnerships that could make long-term care costs more predictable and expand service options for consumers.

While Medicare and Medicaid already are burdened by high costs, public programs designed to meet the needs of the elderly will become increasingly strained in the years ahead. One of the crucial questions facing policymakers, therefore, is how to create an appropriate balance between public and private responsibilities – between the obligation of government to provide a safety net

for those who need it and the obligation of citizens to provide for themselves to the extent they are able to do so.

The Costs of Long-Term Care

According to the Government Accountability Office (GAO), Medicaid currently pays for about 45 percent of all long-term care expenditures, followed by out-of-pocket payments (23 percent), Medicare (14 percent), and private insurance (11 percent). Other public and private sources account for the remaining 7 percent.[1] The Congressional Budget Office (CBO) has projected that the cost of providing long-term care services nationwide to the growing elderly population will nearly triple in real terms over the next 40 years.[2]

The scope of the long-term care funding problem is particularly clear when costs are examined on an individual level. Genworth Financial, an AHIP member, has been commissioning annual cost of care studies since 2001. The most recent study[3], based on information gathered in January and February 2006, includes the following findings:

- Nationally, the average annual cost for a private nursing home room (single occupant) is $70,912 ($194.28/day), reflecting a 2.2 percent increase over 2005 rates ($190.20/day). The average cost of care for a private room in urban areas is 17 percent greater than in non-urban areas. Louisiana has the lowest average annual cost for a private room ($42,304), while Alaska has the highest average annual cost ($191,140).

- Nationally, the average annual cost for a semi-private room (double occupancy) is $62,532 ($171.32/day), a 2.3 percent increase over 2005 rates ($167.44/day).

- Nationally, the average monthly cost for a private one-bedroom unit in an assisted living facility (ALF) is $2,691.20 (a daily rate of $88.48), reflecting a 6.7 percent increase over 2005 survey rates ($2,522/month). These rates do not include any one-time community or entrance fees. Approximately 33 percent of the ALFs surveyed charge a one-time fee, commonly referred to as a community or entrance fee, ranging from $50 to $8,490, with a national average one-time fee of $1,369.68.

[1] David Walker, Comptroller General, Government Accountability Office (GAO), Testimony, March 21, 2002
[2] Congressional Budget Office, *The Cost and Financing of Long-Term Care Services*, Testimony, April 27, 2005
[3] Genworth Financial, *2006 Cost of Care Survey*, March 2006

- Across all home health care provider types, the average hourly rate for home health aides is $25.32, a 13 percent increase over 2005 survey results. The average hourly rate for homemaker services is $17.09, a 3 percent increase over 2005 survey results.

These figures translate into financial obligations that few families have the resources to meet.

Common Misconceptions

At the same time, public attitudes about long-term care are skewed by three widespread misconceptions: (1) that the risk of needing long-term care is relatively remote; (2) that the costs of such care are considerably lower than is actually the case; and (3) that Medicare and Medicaid can fully provide care should the need arise.

On each of these three points, the realities are dramatically different than the perception:

- The risk of eventually needing long-term care, far from being remote, is quite high. Today, 44 percent of people reaching age 65 eventually will spend some part of their lives in a nursing home.[4] It will take time and public education to make Americans more aware of the risks associated with needing long-term care in old age.

- A recent public opinion poll found that one-third of those surveyed believe nursing home care currently costs less than $40,000 a year – less than 60 percent of actual costs.[5]

- Perhaps the most serious misconception, however, is that there is an adequate public safety net in place to protect those who need long-term care. The belief appears to be widespread that Medicare and Medicaid will somehow meet these needs. The reality is that neither program offers adequate protection.

The Role of Medicare and Medicaid

Medicare, the federal health insurance program for the elderly and disabled, is designed primarily to pay for acute care services provided by hospitals and physicians. While Medicare

[4] Congressional Budget Office, *Financing Long-Term Care for the Elderly*, April 2004
[5] Kaiser Family Foundation Public Opinion Spotlight, http://www.kff.org/spotlight/longterm/10.cfm

does cover some nursing home care for patients following a hospital stay, its coverage is limited to 100 days, which by definition, excludes those who need ongoing assistance.

Medicaid, the joint federal-state program for low-income individuals, does pay for long-term care – but only for those who have exhausted nearly all of their own resources. Because Medicaid is a means-tested program, qualifying for assistance requires proving that one is impoverished, or nearly so.

Another harsh reality is that becoming eligible for Medicaid can mean losing control over how and in what setting long-term care will be delivered. Covered services vary substantially from state to state, as does the quality of care. Some states that have been relatively generous about authorizing long-term care services at home have experienced runaway costs and have been forced to scale back such arrangements. For many who rely on Medicaid, their only option is to enter a nursing home, even if they would prefer home care.

The recent expansion of long-term care partnerships, discussed in the following section, was an important step toward creating opportunities for individuals to purchase long-term care coverage and reduce the burden on public programs.

III. IMPLEMENTATION OF EXPANDED LONG-TERM CARE PARTNERSHIPS

AHIP applauds Congress for expanding public-private long-term care "partnerships" under the Deficit Reduction Act of 2005 (DRA). The Energy and Commerce Committee deserves special recognition for its work on this legislation. The partnerships authorized by the DRA will allow many Americans to receive the financial protection provided by long-term care insurance while also ensuring that Medicaid will play a role in meeting the needs of those who require extended long-term care stays.

Building upon the innovative partnerships that already have been implemented in New York, California, Connecticut, and Indiana, this legislation creates powerful new incentives for more Americans living in all states to prepare for the future by purchasing long-term care insurance. Individuals who purchase partnership policies will have the added peace of mind of knowing that if their policy benefits are exhausted, the government will cover the costs of their continuing care through Medicaid without first requiring them to "spend down" their life savings and become impoverished.

In recent years, sales of partnership plans in the four states that have operated them have steadily increased. Between 1996 and 2004, partnership enrollment increased from 28,000 to 172,000.[6] Independent research indicates that partnership plans are attracting enrollees who generally would not buy non-partnership long-term care insurance. Further, research indicates that the partnership enrollees have lower incomes and fewer assets than other long-term care insurance purchasers.[7]

Next Steps

While the passage of this legislation is a major accomplishment, the next step is for the Department of Health and Human Services (HHS) to move forward to develop the regulatory structures that will facilitate the implementation of partnerships in the states. The expansion of the partnership program has the full support of the states and they are ready to launch once the regulatory requirements are established for approval of their plans. To date, more than 20 states have enacted or introduced legislation that would enable their state to establish a partnership program. We are working with our members, state officials, and others to develop a template for a fast-track process and streamlined application that states can use to amend their Medicaid plans to include partnership programs.

IV. THE SUCCESS OF PRIVATE SECTOR STRATEGIES IN MEDICAID

While examining the private sector's role in meeting long-term care needs, it is important to recognize that health insurance plans have made an important contribution toward helping Medicaid programs use their limited resources to expand access, improve quality, provide transportation services, and take other steps to better serve beneficiaries. More than 20 years of experience demonstrates that Medicaid health plans increase beneficiary access to care and improve outcomes, while ensuring that the federal government and state Medicaid programs receive the highest possible value for the dollars they spend on health care.

Increasingly, health plans are proving that integrated systems of care work well for beneficiaries who are dually eligible for Medicaid and Medicare, who qualify for Medicaid through eligibility in the federal Supplemental Security Income (SSI) program, and other beneficiaries with long-

[6] Letter to the Honorable Charles E. Grassley re: Overview of the Long-Term Care Partnership Program, Government Accountability Office (GAO), September 9, 2005, p. 4 of the enclosure and "Partnership Insurance: An Innovation to Meet Long-Term Care Financing Needs in an Era of Federal Minimalism," Mark R. Meiners, Hunter L. McKay, and Kevin J. Mahoney, Journal of Aging and Social Policy, Vol. 14, No. 3/4, 2002, p. 87

[7] Meiners, McKay, and Mahoney, 2002, p. 87

term health care needs. Innovative programs in Minnesota and Texas demonstrate that Medicaid health plans effectively coordinate care for beneficiaries with long-term care needs. Health plans operating in these states have shown that private plan techniques including care coordination, the design of individualized treatment regimens, and encouraging more community-based care improve health outcomes, reduce costs, and deliver high levels of patient satisfaction while maintaining high quality of care. For example:

- Health plans participating in the Texas STAR+PLUS program (includes dual eligibles and beneficiaries eligible for the federal SSI program) reduced emergency room visits by 40 percent and reduced inpatient admissions by 28 percent while promoting quality care. The STAR+PLUS program saved the state $17 million dollars – in just one county – in the first two years.

- A CMS evaluation of the Minnesota Senior Health Options (MSHO) program found dually eligible beneficiaries had fewer preventable emergency room visits and were more likely to receive preventive services after enrolling in a Medicaid health plan. MSHO enrollees report a 94 percent satisfaction rate with their care coordinators.

UnitedHealth Group, through its affiliate, Evercare, has worked with six states, including early efforts in Florida, Arizona and Minnesota, to develop a model that addresses the problems of fragmentation in our health and long-term care systems for people with chronic illness and disabilities. These programs pair a personal care manager with comprehensive services, including acute, nursing home, home- and community-based, behavioral health, and pharmacy care. These programs have had documented success in reducing acute events, such as emergency room visits and hospitalizations, and allowing individuals to remain in their communities and avoid costly nursing home placement.

Another AHIP member, UCare Minnesota, is improving the health and well-being of beneficiaries through its participation in the MSHO program mentioned earlier. To understand the value of this program, consider the circumstances of a 75-year-old resident of Ramsey County – "Mr. O" – who had diabetes and heart disease when he joined MSHO. Before joining UCare, Mr. O's health began declining further because he wasn't able to manage his own care and the basic activities of daily living. He was hospitalized four times in the year before he joined UCare.

Once Mr. O joined UCare, his health and life began to improve. His care coordinator made sure that Mr. O had regular appointments with his primary care clinic. She arranged for Meals on

Wheels to bring healthy meals each day. She also arranged for a skilled nurse to visit every other week. The coordinator also had a home health aid come in three times a week to help him with personal care, such as bathing, grooming, and dressing. In addition, the coordinator arranged for a service to help with homemaking and weekly chores. Once Mr. O's health and home life improved, so did his outlook on life. He told the care coordinator that she is his "ray of sunshine" because of the help she has given him.

As we see the benefits of this coordination, AHIP members are playing leading roles in many states in the effort to coordinate the Medicare and Medicaid programs for dually eligible beneficiaries. This type of integration has been discussed for many years and practiced successfully in a few areas. Now, through the Medicare Special Needs Plans that were authorized by the Medicare Modernization Act of 2003 (MMA), a growing number of plans are coordinating both acute care and long-term care services for dual eligible beneficiaries. The addition of a prescription drug benefit to Medicare and the growth of Medicare Advantage availability across the nation have created new incentives for states to align care for dually eligible beneficiaries.

States now have an opportunity to facilitate coordination and higher quality care for these beneficiaries, and AHIP members are uniquely positioned to bring their health care delivery competencies to this partnership. By tailoring benefits, delivery systems, and provider networks to meet the specific needs of these vulnerable beneficiaries, Special Needs Plans can provide access to high quality care without the disruptions that these seniors would otherwise encounter in accessing benefits from two separate programs. The early experience with Special Needs Plans indicates that this integration of benefits can succeed in providing beneficiaries with better health care across the entire continuum of services they need.

While this success is encouraging, we see certain challenges – for beneficiaries, states, and the Medicare program – arising from the differences in the benefits covered and the providers participating in the Medicare and Medicaid programs. To ensure that Medicare and Medicaid integration continues to grow, it will be important to align incentives. Later in this testimony, we discuss steps that can be taken to remove barriers and improve our nation's long-term care policy. One critical step for further integration of care for dually eligible long-term care beneficiaries will be to readjust the calculation of the federal upper payment limit (UPL) for supplemental payments made by states to publicly owned hospitals and facilities.

V. THE ROLE OF PRIVATE LONG-TERM CARE INSURANCE

Approximately 10 million Americans have purchased long-term care insurance.

According to an AHIP study, consumers with long-term care insurance are 66 percent less likely to become impoverished to pay the costs of long-term care, and long-term care insurance reduces the out-of-pocket expenses of disabled elders. Those with private long-term care insurance receive an average of 14 more hours of personal care per week than similarly disabled non-privately insured elders. Another benefit of long-term care insurance is that it allows those with chronic illnesses and the disabled to remain in their homes. Approximately half of patients and family caregivers interviewed by trained nurses and social workers said that in the absence of their long-term care insurance benefits, the patients would not be able to remain in their homes and would have to seek institutional alternatives.[8]

Long-term care insurance also can reduce state and federal Medicaid expenditures and federal Medicare home health expenditures. According to the AHIP study mentioned above, Medicaid savings are projected to total about $5,000 for each policyholder with long-term care insurance and Medicare savings are estimated to exceed $1,600 per policyholder. Aggregate savings to Medicare and Medicaid for the current number of policyholders are estimated at about $30 billion. These savings will grow as more people acquire policies and the average age of purchasers continues to decline.

Types of Long-Term Care Insurance and Benefits

Several types of long-term care insurance policies are available to consumers. Most are known as either "indemnity" or "expense incurred" policies. An indemnity or "per diem" policy pays up to a fixed benefit amount. With an expense-incurred policy, consumers choose the benefit amount when they buy the policy and they are reimbursed for actual expenses for services received up to a fixed dollar amount per day, week, or month.

Many companies also offer "integrated policies" or policies with "pooled benefits." This type of policy provides a total dollar amount that may be used for different types of long-term care services. There is usually a daily, weekly, or monthly dollar limit for covered long-term care expenses. For example, under a policy with a maximum benefit amount of $150,000 of pooled benefits, the consumer would receive a daily benefit of $150 that would last for 1,000 days if he

[8] AHIP, *Benefits of Long-Term Care Insurance: Enhanced Care for Disabled Elders, Improved Quality of Life for Caregivers and Savings to Medicare & Medicaid,* September 2002

or she spent the maximum daily amount on care. However, if their care costs less, they would receive benefits for more than 1,000 days.

A number of companies offer "hybrid" products that combine long-term care benefits with another insurance product. For example, one type of hybrid that links long-term care insurance to life insurance provides protection against long-term care expenses while at the same time paying a death benefit if the policyholder dies without ever requiring long-term care services.

Consumers generally have a choice of daily benefit amounts ranging from $50 to more than $300 per day for nursing home coverage. Because the per-day benefit purchased today may not be sufficient to cover higher costs years from now, most policies offer inflation adjustments. In many policies, for example, the initial benefit amount will increase automatically each year at a specified rate (such as 5 percent) compounded over the life of the policy.

Long-term care insurance policies contain a wide range of benefit options at moderately priced premiums. For example:

- Long-term care insurance plans offer coverage of nursing home, assisted living facility, home health care, and hospice care. On a case-by-case basis, plans also provide certain alternate care services not listed in the policy (e.g., covering a stay in a special Alzheimer's facility or building a wheelchair ramp to allow the individual to remain in his or her home), subject to the policy's benefit limits.

- Other common benefits include care coordination or case management services, support with activities of daily living, medical equipment coverage, home-delivered meals, spousal discounts, and survivorship benefits. Plans also commonly cover caregiver training to ensure that caregivers learn basic techniques for safely caring for patients in their homes (e.g., transferring patients from their bed to a chair). In addition, virtually all plans cover respite care, designed to pay for brief periods of formal care to provide relief to caregivers.

- Plans contain provisions that guarantee their renewability, have a 30-day "free look" period, cover Alzheimer's disease, provide for a waiver of premiums once a claim is processed, and give policyholders the option of covering nursing home stays without limits or caps.

- Age limits for purchasing coverage also are expanding. Our members now offer individual policies to people as young as 18 and as old as 99. In addition, recognizing that consumers want to plan ahead for their long-term care needs, plans offer inflation protection for the

dollar value of a purchased benefit at an annual 5 percent compounded rate, funded with a level premium that stays the same from one year to the next. Companies also offer plans that have a non-forfeiture benefit that allows beneficiaries to retain some benefits if they lapse their policy.

The growth in employer-sponsored plans is especially encouraging. The average age of the employee electing this coverage is 45 – compared to an average age of 60 for persons who buy long-term care insurance outside of the employer-sponsored market. To date, over 2 million policies have been sold through more than 6,000 employers, and accounts for about one-fourth of the long-term care insurance marketplace.

Premiums for long-term care insurance policies depend on multiple factors, including the entry-age of the policyholder and comprehensiveness of the benefit package selected. At the same time, the subcommittee should be aware that average premiums have remained stable over time. AHIP estimates that a vast majority of long-term care policies currently in effect today have never experienced a rate increase. In addition, within the past few years there have been significant enhancements to long-term care insurance. For example, prior hospitalization requirements have been eliminated and benefits have been expanded to include coverage in assisted living facilities, adult day care and home health care, in addition to nursing home care, thus giving buyers more benefits for their premium dollars.

Examining Who Buys Long-Term Care Insurance

AHIP recently commissioned a study[9], conducted by LifePlans, Inc., to identify who buys long-term care insurance in the individual market and understand what motivates them to do so. Ten insurance companies participated in this study, representing more than 80 percent of total sales of long-term care insurance policies in 2005. These companies contributed a sample of 1,274 buyers, 214 nonbuyers, and design information on 8,208 policies. In addition, 500 individuals age 50 and over were surveyed from the general population. This study builds upon similar work completed in 1990, 1995, and 2000.

The study's key findings include the following:

- The average age of individual purchasers of long-term care insurance declined from 67 years to 61 years between 2000 and 2005. Two-thirds of all individual long-term care policies sold

[9] LifePlans, Inc., *Who Buys Long-Term Care Insurance in 2005? A Fifteen Year Study of Buyers and Nonbuyers,* April 2006

are now purchased by people younger than 65. The major demographic differences between buyers and nonbuyers are that the latter tend to be somewhat older, less likely to be employed, and have lower incomes than buyers of long-term care insurance. In 2005, 71 percent of buyers had incomes exceeding $50,000, 13 percent had incomes between $35,000 and $50,000, and another 13 percent had incomes between $20,000 and $35,000.

- Buyers are almost twice as likely as nonbuyers to strongly agree that "it is important to plan now for the possibility of needing long-term care services." On another key statement, nonbuyers are more than twice as likely as buyers to agree that "the government will pay for most of the costs of long-term care if services are ever needed." Nonbuyers also were much more likely than buyers – 70 percent versus 14 percent – to underestimate the cost of a nursing home in their area.

- In examining the coverage offered by long-term care insurance policies, the study found a trend toward the purchase of comprehensive coverage. In 2005, 90 percent of policies sold were comprehensive (i.e., covering both institutional care and home care) – compared to 77 percent in 2000 and 37 percent in 1990. Over the past five years, the average daily nursing home benefit has increased by 30 percent. In addition, more than three-quarters of buyers chose some form of inflation protection in 2005, up from 41 percent in 2000.

- A highly significant finding from the 2005 study is that more than 80 percent of current nonbuyers would be more interested in buying a policy if they could deduct premiums from their taxes. Approximately three-fourths of nonbuyers said they would be more interested in buying long-term care insurance if they thought the government would provide stop-loss coverage once their private insurance benefits ran out or if they felt premiums would remain stable over time.

Consumer Protections – Strengthening the Market

The adoption of robust standards for consumer protection has been vital in strengthening the market for long-term care insurance, and our members are committed to providing quality products, transparency in their products, and consumer choice. We view these protections as key to giving consumers confidence, expanding the market, and providing viable solutions to work hand-in-hand with Medicaid coverage for the poor.

In the past, there have been questions about post-claims underwriting. Our position is that this is never justifiable. On the other hand, efforts to detect and prevent fraud should not be viewed as

post-claims underwriting. AHIP supports the strong stand taken on this issue by the National Association of Insurance Commissioners (NAIC). We also support the NAIC's most recent Long-Term Care Insurance Model Act and Regulations.

To give the committee a broad picture of the value of the NAIC provisions, below are some of the key requirements:

- policies must be guaranteed renewable or noncancellable;
- limitations apply to the use of pre-existing conditions and prior hospitalization requirements;
- policies cannot limit or exclude coverage by type of illness, treatment, medical condition or accident;
- policies must contain continuation or conversion of coverage provisions;
- policies must provide numerous disclosures, including an outline of coverage and safeguards to prevent unintended lapses of policies;
- post-claims underwriting is prohibited;
- minimum standards are established for home health benefits;
- policies must contain suitability provisions that provide standards for appropriate long-term care insurance purchases;
- policies must offer inflation protection;
- policies must offer non-forfeiture of benefits and, if declined, the provision of contingent benefits upon lapse; and
- requirements address premium rate stability, including disclosure to consumers relating to rate stability.

VI. RECOMMENDATIONS FOR NEXT STEPS

Above-the-Line Federal Income Tax Deduction for LTC Insurance Premiums

AHIP supports federal legislation to enact an above-the-line tax deduction for long-term care insurance premiums. This legislation has been introduced in every legislative cycle since 1999-2000 and the current level of support reflects growing congressional interest in this issue.

The proposal for an above-the-line tax deduction would allow taxpayers to claim a tax deduction regardless of whether they itemize their deductions and regardless of whether they have other medical expenses. For example, a person who pays $1,500 in premiums for long-term care insurance could reduce his or her taxable income by the full $1,500 under this proposal.

By contrast, current law allows taxpayers to deduct premiums for long-care term insurance only if they itemize deductions and only to the extent that their medical expenses exceed 7.5 percent of their adjusted gross income. In other words, a person with an adjusted gross income of $40,000 must have $3,000 in medical expenses before he or she can claim any tax deduction for long-term care insurance premiums or any other medical expenses. Because this threshold is so high under current law, fewer than five percent of all tax returns report medical expenses as itemized deductions. An above-the-line tax deduction would eliminate this 7.5 percent threshold and allow all long-term care insurance policyholders to claim a tax deduction.

AHIP estimates that an above-the-line tax deduction for long-term care insurance premiums would reduce premiums by about 19 percent and, additionally, increase the number of individuals purchasing long-term care insurance by 14 percent to 24 percent.[10] A strong educational campaign would further increase these projected growth rates.

As Congress considers federal tax incentives, we urge lawmakers to recognize that more than 20 states have enacted enhanced tax incentives for the purchase of long-term care insurance. These states are: Alabama, California, Colorado, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Minnesota, Missouri, Montana, New York, North Carolina, North Dakota, Ohio, Oregon, Utah, Virginia, West Virginia, and Wisconsin. These state laws have taken an important first step to enhance the affordability of long-term care insurance. By enacting an above-the-line tax deduction at the federal level, Congress can create a more powerful incentive – with the states working in partnership – for all Americans to protect themselves against the financial risk of long-term care needs.

[10] AHIP, *Tax Deductibility of Long-Term Care Insurance Premiums*, March 2000

Offering LTC Insurance Under Cafeteria/FSA Options

AHIP also strongly supports legislative provisions that would enable employers to offer long-term care insurance as an option under cafeteria plans and flexible spending arrangements (FSAs). We urge subcommittee members to support inclusion of these provisions in the conference report for H.R. 2830, the "Pension Protection Act." While we recognize that budgetary constraints may prevent Congress from taking action this year on other more ambitious proposals, we are confident that enactment of this legislation – despite its relatively modest price tag – would yield significant progress in increasing the number of Americans who protect themselves against the high cost of long-term care.

Enactment of the cafeteria/FSA proposal goes hand-in-hand with the expansion of long-term care partnerships. This legislation would make long-term care insurance more affordable to more Americans and, in doing so, help to ease some of the financial pressure that long-term care costs are imposing on Medicaid and Medicare. At a time when state and federal budgets are severely strained by health-related costs, this provision offers a common sense solution for reducing this burden on taxpayers and helping more Americans prepare for their future long-term care needs.

It is also important to recognize that employers are uniquely positioned to increase awareness about the value of long-term care insurance. This provision would allow employers to include information about long-term care options in their employee benefit packages and help employees make sound decisions.

Cafeteria plans, which allow employees to customize their benefits packages, and flexible spending arrangements, which allow employees to use pre-tax dollars to pay for medical expenses not covered by health insurance, are valuable employee benefit tools that can be made even more effective for American workers with enactment of this legislation. Allowing employees to purchase long-term care insurance on a pre-tax basis through these popular employee benefit arrangements would allow more families to purchase coverage. Moreover, this would put long-term care insurance on a level playing field with other employer-sponsored benefits – such as 401(k) contributions – that are not taxed.

To date, more than 50 House members – 29 Republicans and 25 Democrats – have cosponsored bills that would allow long-term care insurance to be offered under cafeteria plans and FSAs. We thank members of the subcommittee who support these bills. We stand ready to assist you in promoting final passage of this new option for expanding access to long-term care insurance.

Removing Barriers to Medicaid Managed Care

The federal upper payment limit (UPL) program has proven to be a barrier to expanding Medicaid managed care to beneficiaries. UPL programs provide federal matching funds for supplemental payments made by states to publicly owned hospitals and facilities. UPL payments are based on the amount of inpatient services the public facility provides to Medicaid beneficiaries who are covered under the Medicaid fee-for-service program. Health plan payments to these facilities are not counted in determining the UPL payment, which creates a financial disincentive for states to meet beneficiary needs through Medicaid health plan programs – despite their proven ability to improve health care for the most vulnerable members of the Medicaid population.

AHIP supports a solution that would allow states to continue to expand beneficiary access to effective managed care programs while continuing to support safety net providers and maintain funding levels for their Medicaid programs. Medicaid health plan payments to public facilities should be included for purposes of determining the UPL payment. This proposal is consistent with the manner other supplemental payments – for example, disproportionate share hospital payments and payments for graduate medical education – are currently made. This proposal would remove the barrier that currently exists to expanding beneficiary access to systems of care that improve their well-being in a cost-effective manner.

Exploring Best Practices and Demonstrations

To better meet the needs of the long-term care population, policymakers should explore opportunities to address the following priorities through Medicaid:

- maximizing consumer self-direction, independence and health in homes and communities;
- promoting models of coordinated, multi-disciplinary, continuous care and support across all settings and throughout the life spans (in contrast to a model of intermittent, episodic care); and
- emphasizing prevention for patients (risk assessment, early identification and intervention).

Creating a Presidential Commission to Address the Nation's Long-Term Care Needs

This commission would make recommendations to Congress and the Administration for accomplishing a wide range of goals including:

- exploring how to create a seamless long-term care continuum from acute to chronic care;

- exploring tax incentives to encourage individuals to take planning responsibility for their own long-term care needs;
- exploring how to redesign Medicaid to allow dollars to follow the person across all settings, ensuring that access to quality long-term care and services can be received in the settings of choice; and
- exploring the potential to increase utilization of technology (telehealth, monitoring devices, electronic medical records, etc.) in all care settings – particularly in rural settings.

Establishing a Federal Office to Address Long-Term Care Workforce Issues

A federal office should be established to address professional and paraprofessional long-term care workforce issues and provide recommendations to improve the recruitment, training, retention and practice of a strong long-term care workforce.

Establishing a Quality Agenda for Long-Term Care

Congress and the Administration, in collaboration with consumers, providers and other stakeholders, should establish a uniform quality agenda for long-term care and supportive services, including measurement and reporting across the continuum of services and settings, and performance-based payment, taking into account consumer satisfaction, health literacy, and progress in addressing disparities. Recognizing the efforts underway by the Ambulatory Care Quality Alliance (AQA), the Hospital Quality Alliance (HQA), and the Pharmacy Quality Alliance (PQA), a similar public-private collaboration is needed to address quality challenges in long-term care settings.

VII. CONCLUSION

We appreciate this opportunity to testify about these important issues and look forward to continuing to work with the subcommittee to advance policy solutions to help all Americans prepare for their future long-term care needs.